AMERICAN GENERAL FINANCIAL GROUP

The United States Life Insurance Company in The City of New York

Member American General Financial Group

HEALTHPLEX, INC. **DENTAL STATEMENT** **POLICY NUMBER G22,154**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

ORIGINAL BILLS ARE ALWAYS REQUIRED EXCEPT WHEN UNITED STATES LIFE IS THE SECONDARY CARRIER.

EMPLOYEE'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY).

1. Mr. ☐ Mrs. ☐ Miss ☐ _____ (PRINT NAME) Date of Birth _____ Marital Status _____

2. Claim is made for: ☐ Self ☐ Spouse ☐ Child (CHECK WHICH) _____ (PRINT NAME)

3. Patient's Social Security Number _____ Date of Birth _____ Sex _____

4. Home Address _____ (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE) Telephone No. _____

5. List all other group insurance or prepayment plans providing benefits for this injury or sickness. If none, state "None."

_____

_____

COMPANY DAY INSURED BENEFIT PROVIDED

6. If dental treatment was required due to accident, give date and details of accident.

_____

_____

7. If claim is for child over 19 years, is that child a full-time student? ☐ Yes ☐ No If yes,
Where? _____ Employed? _____ Where? _____

Married? _____

To all physicians and other medical professionals, hospitals and other medical-care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators:

You are authorized to provide The United States Life Insurance Company (USL) and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on USL's behalf, with information concerning medical care, advice, treatment or supplies provided the Patient, including information relating to mental illness and drug abuse or alcoholism, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administrating claims for benefits.

I understand that this authorization is valid for the duration of my claim for benefits under USL's policy.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Signed this _____ day of _____ _____ (YEAR)

_____ SIGNATURE OF EMPLOYEE

_____ SIGNATURE OF PATIENT IF OTHER THAN MINOR CHILD

INSTRUCTIONS FOR SUBMITTING A CLAIM

1. Please answer all the questions in the section entitled "EMPLOYEE'S STATEMENT." Be sure to include the PATIENT'S Social Security number.
2. Complete questions 1 through 15 on the reverse side of this form. Be sure to fill in the EMPLOYEE'S Social Security number on question 7.
3. Sign and date the Authorization To Release Information.
4. If you wish to have your benefits paid directly to the Dentist, sign and date the Authorization To Pay Benefits Directly To Dentist.
5. Have the Dentist complete questions 16 through 31 and check the appropriate box at the top of the form indicating whether this is a Pre-Treatment Estimate or a Statement of Actual Services.

After the form has been fully completed, send it to:

HEALTHPLEX, INC.
333 EARLE OVINGTON BLVD.
SUITE 300
UNIONDALE, NEW YORK 11553-3608
1-800-468-0600 (PRESS OPTION 1)

ATTENDING DENTIST'S STATEMENTS

CHECK ONE:
- ☐ DENTIST'S PRE-TREATMENT ESTIMATE
- ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

The United States Life Insurance Company

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER | 3. SEX: M | F | 4. PATIENT BIRTHDATE: MO | DAY | YR | 5. IF FULL-TIME STUDENT: SCHOOL | CITY

6. EMPLOYEE/SUBSCRIBER NAME: FIRST MIDDLE LAST | 7. EMPLOYEE SUBSCRIBER SOCIAL SECURITY NO. | 9. NAME OF GROUP DENTAL PROGRAM: Policy No. G22514

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS | 10. EMPLOYER (COMPANY) NAME AND ADDRESS: COUNTY OF NASSAU

CITY, STATE, ZIP | MINEOLA, N.Y.

11. GROUP NO. | 12. LOCATION (LOCAL) | 13. ARE OTHER FAMILY MEMBERS EMPLOYED: EMPLOYEE NAME, SOCIAL SECURITY NUMBER, DATE OF BIRTH | 14. MAIL AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT, OR PARENT IF MINOR) | DATE | SIGNED (INJURED PERSON) | DATE

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

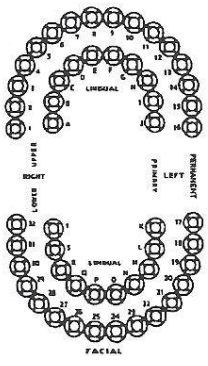
18. DENTIST (SOC. SEC. or T.I.N.) | 19. DENTIST LIC. NO. | 20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) — 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER — DATE APPLIANCES PLACED — MOS TREATMENT REMAINING?

IDENTIFY MISSING TEETH WITH "X"

FACIAL



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN

TOOTH -OR- LET.	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				
		16				
		17				
		18				
		19				
		20				

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED ABOVE: ☐ WILL BE ☐ HAVE BEEN COMPLETED

SIGNED (DENTIST) | DATE:

TOTAL FEE CHARGED	
MAX ALLOWABLE	
DEDUCTIBLE	
CARRIER #	
CARRIER PAYS	
PATIENT PAYS	